USAID/Philippines
Population, Health and Nutrition

Towards Contraceptive Self-Reliance (CSR) in the Philippines USAID Initiative 2002-2006

Working Paper
June 30, 2003

Summary

This document presents the USAID Contraceptive Self-Reliance (CSR) Initiative. It is divided into five sections. Section I provides the background; Section II articulates the purpose and principles of the CSR initiative; Section III presents the approach; Section IV details the USAID actions that will lead to the achievement of CSR in the Philippines; and Section V describes plans for monitoring of results and coordination among stakeholders.

The primary purpose of the USAID CSR Initiative is to:

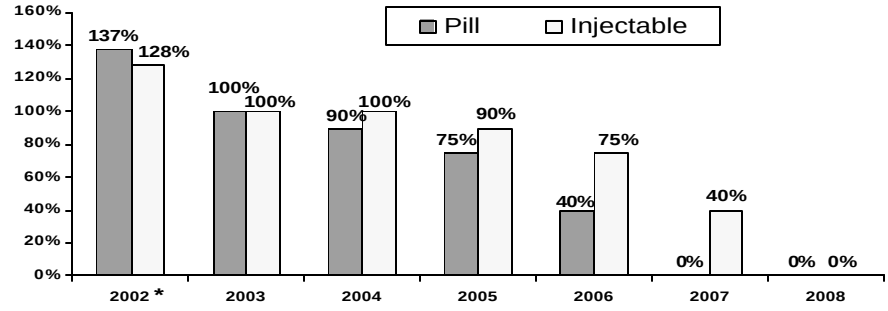
> ***foster the country's ability to sustain quality and affordable family planning services and commodities, within the context of an increasing population and growing contraceptive prevalence rate.***

Specifically, the initiative aims to: 1) help the government reduce its burden of providing free services to all, by focusing its resources to the poor; 2) stimulate greater participation of the private sector to market and sell family planning services and commodities; and 3) provide more access and choices to clients desiring family planning services.

The approach is two-pronged: (1) gradually reduce donor commodity support and focus distribution of donated products to the neediest; and (2) expand and maximize use of private sources for contraceptive commodities not covered by donors.

The reduction in donated pills and injectables is shown in the graph below:

USAID and Other Donors Donated Pill and Injectable Supply as a Percent Required for the Neediest



(D1 and E income group using pills from the public sector = 47.6%)**

(D1 and E income group using injectables from the public sector = 72.2%)**

* 2002 data based on 2002 FPS public sector share of pill and injectable market
** estimated using 2002 FPS and 2000 FIES data; assumed to remain constant from 2002-2008 given no projections for D1 and E public sector pill and injectable users currently available.

The phase out plan for IUDs will be developed at a later date because of the current unavailability of other brands/sources in the country. USAID donations of condoms are phased-out in 2003.

The recommendations to expand and maximize use of internal sources for contraceptives include:

1. GRP procurement of contraceptives;
2. Support to the public sector to focus their resources on serving the poorest;
3. Creation of an environment for expanded private sector participation; and
4. Mobilization or development of financing schemes.

With the intent of contributing to the achievement of CSR in the Philippines, USAID supports the following programs and activities:

1. shifting paying clients to the private sector using market segmentation;
2. strengthening the private sector as an alternative source of services and commodities;
3. building the capacity of LGUs in planning, budgeting, and logistics for contraceptives;
4. expanding private financing schemes, such as PhilHealth;
5. encouraging use of family planning products and services; and
6. advocating appropriate CSR measures to policymakers, the private sector and other key stakeholders.

Towards Contraceptive Self-Reliance (CSR) in the Philippines
USAID Initiative

2002-2006

I. Background

As reported in the NSO 2000 Census, the Philippines has a population of 76.5 million people and is growing by almost 1.7 million every year. Although it started from a relatively privileged position in the 1950s, the Philippines has never experienced the economic growth of its Asian neighbors. The 2000 Census reported that per capita GDP dropped from $1,019 in 1999 to $977 in 2000 and that the percentage of Filipinos below the government of the Republic of the Philippines' (GRP) official poverty line increased from 36.8% in 1997 to 39.4% in 2000. For theses reasons, the GRP's number one priority is to reduce poverty and spur economic growth.

Philippine leaders have identified the reduction of population growth as one of the country's most critical development problems. If the current growth rate of 2.36% (Source: NSO 2000 Census) were to continue, the country's population would double in just over 30 years. This extremely high population growth rate will continue to drain scarce resources and limit the country's potential for accelerating economic growth.

Fertility reduction is a matter of concern for the welfare of individual families as well as for the country and its development prospects. As of 1998, average total fertility was 3.7 children per woman; while wanted fertility was 2.7 children per woman (1998 NDHS). Almost 20 percent of Filipino women, numbering around three million, have unmet need for family planning, either because they want to space their next child (8.6 percent), or because they want no more children (11.2 percent) but are not using contraception to help them achieve those desires. This number is even greater if women who are relying on less effective family planning methods are not counted as having met their desire for family planning.

Improving contraceptive use is an effective way to help women meet their desired family size. The contraceptive prevalence rate (CPR) for modern methods increased to 35.1% in 2002 from 24.9% in 1993. The average increase in modern CPR from 1993 to 2002 was 1.13 percentage points per year (Source: 2002 FPS Survey).

But problems in family planning service expansion and sustainability remain. Modern CPR levels must increase to 40% (i.e., around 6.2 million women using modern contraception) if women are to achieve their desired family size. This is a large increase, which the public sector by itself surely cannot meet. A large private sector remains a major under-utilized asset for delivery of family planning services. It is becoming increasingly clear to the GRP that it needs to utilize its own resources and tap private sector capacity more effectively, both to meet current needs and ensure sustainability of service provision in the future, and that donor assistance can help the GRP address that need.

Thus, in 1999, the GRP promulgated a Contraceptive Independence Initiative (CII) policy to move the country to more self-reliant provision of these commodities. The USAID CSR Initiative is part of this broader GRP initiative.

With Philippine Population Commission (POPCOM) taking the lead, a multi-sectoral task force was created to develop the GRP's CII framework that led to the DOH issuance of a National Family Planning Program Policy in September 2001. This policy categorically stated that the GRP would assume greater responsibility for the family planning program. Specifically, in page 9, under the Health Financing, the policy stated that "…to encourage self-sufficiency and eliminate dependence on foreign donors for FP services and commodities, the program shall adopt the recommendations of the technical working groups on the Contraceptive Independence Initiative (CII). The CII will segment the population and will ensure the availability of commodities for all segments through direct subsidy, health insurance, socialized pricing and/or commercial procurement."

Between May to October 2002, USAID presented the broad framework of the USAID CSR Initiative to various stakeholders including the donor community (May 2002), key officials of the Department of Health, POPCOM, and PhilHealth (June 2002 and confirmed in official letters to the DOH and NEDA Secretaries in July 2002), and business leaders (October 2002).

Other developments occurred since 1999 that are favorable to the success of a contraceptive self-reliance initiative, such as the government being supportive of private sector provision of FP services and commodities, and the inclusion of funds in the DOH 2000 budget for contraceptive procurement.

However, the urgency of achieving CSR at a faster pace is clear, because of increasing population growth and the total population reaching almost 80 million. The continued supply of donated contraceptives is slowing down the country's ability to become self-reliant in providing much-needed, good quality family planning services in the country. Hence, the USAID CSR Initiative entails phasing out of commodity support while at the same time increasing other forms of assistance for family planning services.

II. Purpose and Principles

The purpose of the USAID CSR Initiative is:

> ***To foster the country's ability to sustain the provision of quality and affordable family planning services and commodities, within the context of an increasing population and a growing contraceptive prevalence rate.***

Specifically, the initiative aims to:

1. Help the government reduce its burden of providing free services to all, by focusing its resources to the poor;

2. Stimulate greater participation of the private sector to market and sell family planning services and commodities; and

3. Provide more access and choices to clients desiring family planning services.

The initiative is premised on the following:

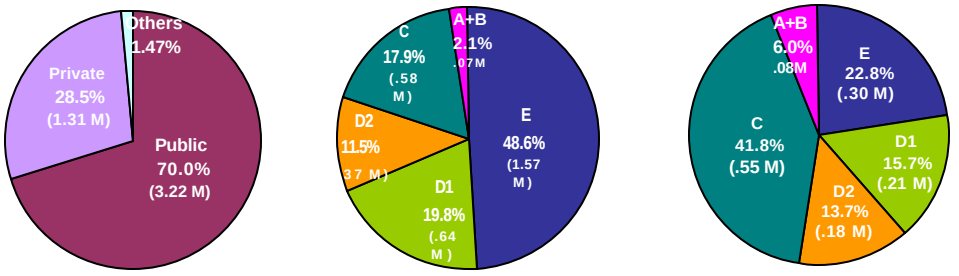
1. ***The GRP continues to have main responsibility for meeting family planning needs of the country.***

   The USAID CSR Initiative supports the GRP (local and LGU contribution) in fulfilling its role in meeting the country's family planning needs and implementing the Philippine National Family Program Policy.

2. ***Total commodity donations are distributed to benefit the poor.***

   A recent market study by The Futures Group, using 2002 FPS and 2000 FIES data, indicates that approximately 2% of family planning clients at government facilities are in the A&B (higher income) category; 18% are in the C (middle income) category; 12% are in the D2 (lower middle) category; 20% are in D1 (lower income); and 49% are in the E (low income) category as shown in the charts below.

Public and Private Market Share of More Effective Methods (Pill, IUD, Injectables, Condom, Sterilization) By Income Classification



4.6 Million WRA *

3.22 Million WRA
Public Sector Clients

1.31 Million WRA
Private Sector Clients

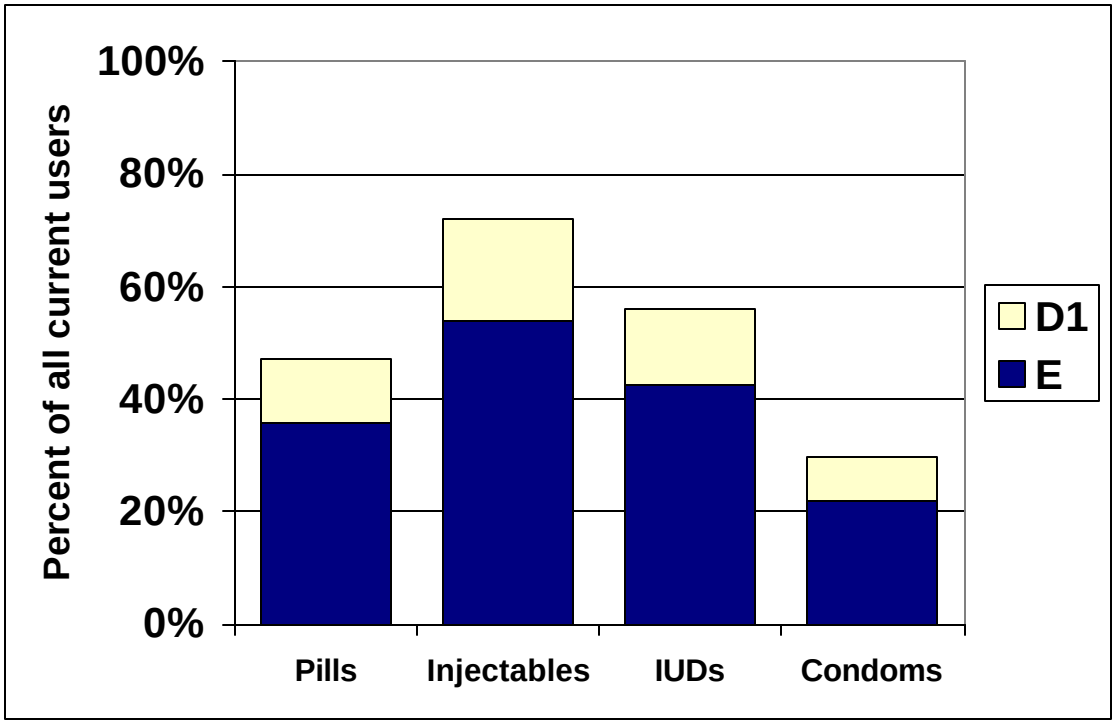
*** Women of Reproductive Age**

Estimated using 2002 FPS and 2000 FIES

For the purpose of this initiative, we assume the neediest who are unable to pay for services are those in the E and D1 income categories. The above charts show that approximately one third of the "free" public sector program contraceptives are distributed to those who can afford to pay. In addition, employees or clients of industry-based clinics and non-government organizations that continue to get their supplies from the public sector program have enough disposable income to pay for their contraceptives. The commodities distributed to these non-indigent clients could be better used to serve the needs of the poorest clients, those in the E and D1 categories. Directing the free donated commodities to the poor would protect indigent clients while not reducing the access of upper income clients to family planning commodities.

The market segmentation study also classified all current FP users (the 4.6 Million WRA in the chart shown above) by method and income to determine the safety net or the neediest. The graph below shows that proportions of the FP market that are E and D1 class users who obtain their FP products from public sector sources are 47.6% for pills and 72.2% for injectables.

Safety net needs for public sector services (D1 and E class FP users who rely on the public sector, as a percent of total users), by method (estimated using 2002 FPS and 2000 FIES):



3. ***The reduction in commodity support does not decrease the total assistance to the Philippine Family Planning Program.***

   The U.S. Government has been a major donor providing assistance to the family planning program of the Philippines since 1970. Contraceptive commodities compose a small portion (18%) of USAID's total assistance to the family planning program. The major share of USAID support has been in the form of technical assistance to improve the capacities of LGUs to provide services and commodities; help create national policies and establish systems that increase access to and improve quality of FP services; and expand FP service provision by the private sector.

   From 1990 to 2001, USAID's assistance has averaged about seventeen million ($17 million) U.S. dollars a year. Of this amount, forty million ($40 million) U.S. dollars went to contraceptive procurement (pills, condoms, IUDs and injectables), accounting for 80% of the country's total requirements.

   A reduction in USAID's commodity support does not reduce USAID's assistance to the Family Planning Program but rather shifts the assistance to pay more attention to much-needed technical support.

4. ***Total commodity donations to cover the needs of the poor include the USAID commodities and donations from other donors.***

   USAID shall maintain its contraceptive support through 2004 to meet the needs of those clients of the public sector who cannot pay for commodities. Should other donors provide contraceptive support to the Philippine Family Planning program, the USAID level of support will be reduced correspondingly such that the total donations will be enough to cover the safety net. This balancing of donor support is designed to promote a sense of responsibility and accountability among policymakers as an integral part of good governance, ensuring availability and accessibility of services to the poorest of the poor.

   In 2004, total USAID commodity donations will start to phase down gradually as domestic resources (national and LGU) for the contraceptive requirements of the neediest phase in.

5. ***Fixing the timetable for the phase out of donated commodities is a dynamic process.***

   The following factors have been considered in developing the timetable for each method: 1) pattern of method use; 2) sources and availability of supplies; 3) government procurement system; 3) readiness of Local Government Units (LGUs) to segment its clients; and 4) readiness of the private sector to respond. Major changes in these areas would likely cause adjustments to the timetable.

III. The Approach

Under the Contraceptive Self Reliance (CSR) Initiative, commodity support will be reduced over time according to the following proposed timeline for each method. The initiative also takes into account the potential for expanding and maximizing the use of internal Philippine sources and outlines the assumptions and implications of USAID's reduction in contraceptive procurement.

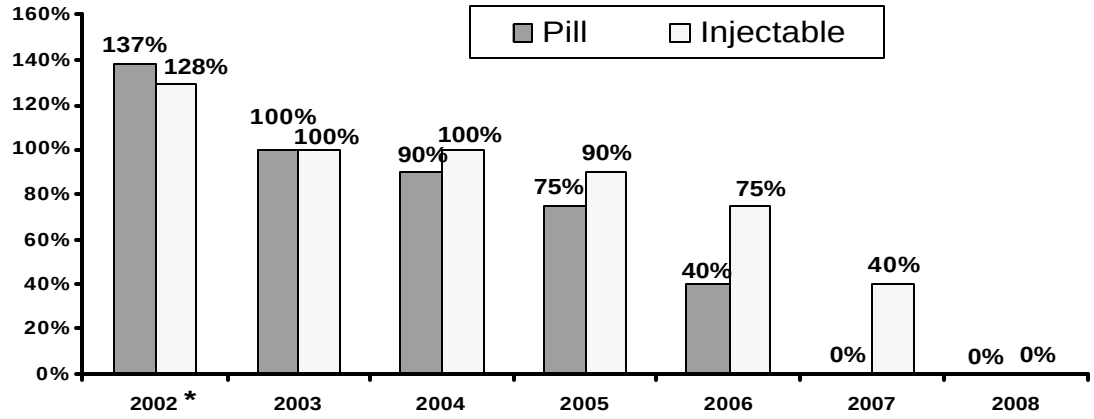
A. Gradual reduction of commodity support

To ensure that the poor continue to have access to "free" family planning services and commodities from public sector providers, the reduction of commodity support is made as percentage coverage of the requirement of the neediest. USAID estimates the following commodity donations through 2008 in order to achieve CSR. The resulting method mixes and sources are described by method.

***Pills*.** In the base year (2002), total commodity donations covered 137% of the requirement of the neediest. While total donations are reduced in 2003, it continues to cover 100% of the requirement of the neediest. In succeeding years, the coverage of the safety are: 90% in 2004, 75% in 2005, 40% in 2006. Total commodity donations of pills is expected to be completely phased-out in 2007.

Injectables. In the base year (2002), total commodity donations covered 128% of the requirement of the neediest. Total donations continues to cover 100% of the requirement of the neediest in 2003 and 2004. In succeeding years, the coverage of the safety are: 90% in 2005, 75% in 2006, 40% in 2007. Total commodity donations of injectables is expected to be completely phased-out in 2008.

USAID and Other Donors Donated Pill and Injectable Supply as a Percent Required for the Neediest



(D1 and E income group using pills from the public sector = 47.6%)**

(D1 and E income group using injectables from the public sector = 72.2%)**

* 2002 data based on 2002 FPS public sector share of pill and injectable market
** estimated using 2002 FPS and 2000 FIES data; assumed to remain constant from 2002-2008 given no projections for D1 and E public sector pill and injectable users currently available.

Condoms. While the CII process began in 1999, the reduction in the USAID contraceptive procurement is effected beginning 2003 with condoms as the first commodity to be phased out. The reasons for this are: 1) condom has a low usage rate for family planning [1.7% usage rate as reported in the 1998 NDHS]; 2) low priced condoms are available in the market; and 3) condoms are easy to procure by the DOH, LGUs and the users themselves [the latest National Statistics Family Planning Survey showed that fifty percent (50%) of condom users get their supplies from pharmacies].

IUDs. The phase out plan for IUDs will be developed at a later date because of the current unavailability of other brands/sources in the country.

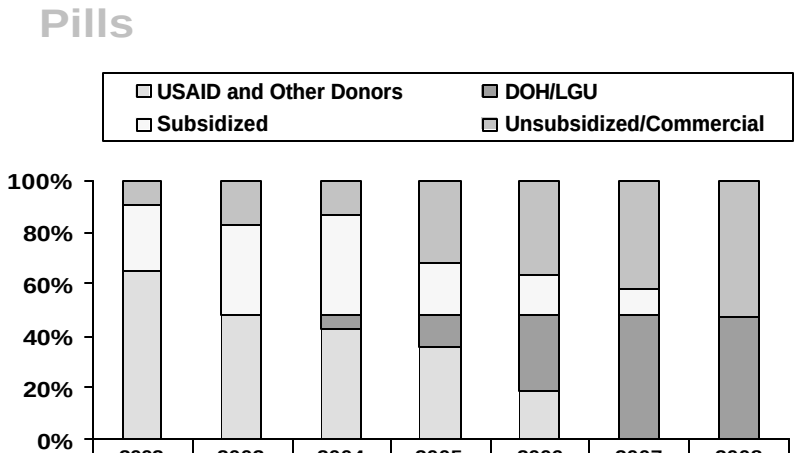
The following are the timelines of pills and injectables through 2008 per method. The base data and assumptions are attached as Annexes 1 - 6.

These timelines were developed to ensure that enough supplies remain available to cover the needs of the poorest and that both government and the private sectors have adequate time to make necessary policy changes and to put systems in place to achieve contraceptive self-reliance.

1. Phase-out timeline for **pills** by source: Percent Share

In the base year (2002), total donations represent 65.4% of the commodities used by current FP clients. This proportion is reduced to 48% in 2003. The reduced levels through 2006 are: 43% in 2004, 36% in 2005 and 19% in 2006. Commodity donations of pills are expected to be completely phased out in 2007. The government is expected to begin to

procure pills in 2004 and cover all the requirement of the neediest beginning 2007. Government procurement as a proportion of the total commodity supply source will phase-in as follows: 5% in 2004, 12% in 2005, 29% in 2006 and 48% in 2007 and in 2008. Subsidized social marketing programs is currently a major source of FP commodities in the market. It is also seen as a transition mechanism while the unsubsized/commercial source begins to phase-in. Thus, the subsidized social marketing programs'proportion as a source of commodities was 25.5% in 2002 and increases to 35% in 2003, to 39% in 2004, then begins to decrease to 20% in 2005, 15% in 2006 and 10% in 2007; while the unsubsidized/commercial source was 9.1% in 2002 and increases to 17% in 2003 and continues to increase to 32% in 2005, 37% in 2006, 42% in 2007 and 53% in 2008. These changes in the sources of pills are shown in the graph below.



	2002	2003	2004	2005	2006	2007	2008
Unsubsidized/Commercial	9.1	17	13	32	37	42	53
Subsidized	25.5	35	39	20	15	10	0
DOH/LGU	0	0	5	12	29	48	48
USAID and Other Donors	65.4	48	43	36	19	0	0

* estimated using 2002 FPS data and 2000 FIES

Notes:

Pills – Transition by Source

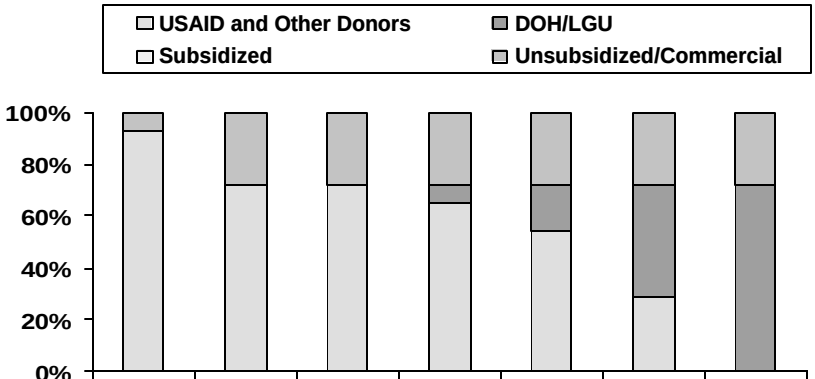
- *USAID and UNFPA's donations to the public sector are included in the USAID & other donors category. (The USAID shipment data is attached as Annex 5. The UNFPA shipment data is attached as Annex 6.)*
- *The Unsubsidized/Commercial category includes the commercial and DKT unsubsidized social marketing of Lady pill.*
- *The Subsidized commercial category represents the DKT subsidized social marketing of Trust pills.*

(D1 and E income group using pills from the public sector – 47.6%)*

2. Phase-out timeline for **injectables** by source: Percent Share

In the base year (2002), total donations represent 92.7% of the commodities used by current FP clients. This proportion is reduced to 72% in years 2003 and 2004. The reduced levels through 2007 are: 65% in 2005, 54% in 2006 and 29% in 2007. Commodity donations of injectables are expected to be completely phased out in 2008. The government is expected to begin to procure injectables in 2005 and cover all the requirement of the neediest by 2008. Government procurement as a proportion of the total commodity supply will phase-in as follows: 7% in 2005, 18% in 2006, 43% in 2007 and 72% in 2008. There are no subsidized social marketing programs for injectables. Therefore, the unsubsidized/commercial source must be further developed to increase its capacity to respond to the FP needs of the country. The unsubsidized/commercial source was 7.3% in 2002 and is expected to increase to 28% beginning in 2003.These changes in the sources of injectables are shown in the graph below.

Injectables – Transition by Source



	2002	2003	2004	2005	2006	2007	2008
Unsubsidized/Commercial	7.3	28	28	28	28	28	28
Subsidized	0	0	0	0	0	0	0
DOH/LGU	0	0	0	7	18	43	72
USAID and Other Donors	92.7	72	72	65	54	29	0

(D1 and E income group using injectables from the public sector = 72.2%)*

* estimated using 2002 FPS data and 2000 FIES

Notes:

- *USAID and UNFPA's donations to the public sector are included in the USAID & other donors category. (The USAID shipment data is attached as Annex 5. The UNFPA shipment data is attached as Annex 6.)*
- *The Unsubsidized/Commercial category includes the commercial and DKT unsubsidized social marketing of DepoTrust.*

B. Expanding and Maximizing Use of Internal Sources for Contraceptives: Potential Responses

1. GRP Procurement of Contraceptives

   The government may need to undertake its own procurement as donated contraceptives phase out to meet the demands of the neediest. For procurement at the LGU level, the most cost-effective method for these procurements would be to establish a centrally-supported procurement or a prime vendor(s) arrangement to obtain competitive pricing. This is also important to foster a sense of value of low cost commodities and services in providers once the LGUs begin to procure contraceptives from their own budget. The national government may also procure supplies for the neediest.

2. Supporting the public sector to focus their resources on serving the poorest

   a. ***Targeting approach***. The reduced USAID commodity support will necessarily limit accessibility and availability of "free" FP commodities and services in the public sector. Procurement of contraceptives by the government is important but not sufficient to cover the gap in commodity requirements. Focusing the limited government resources to serve the poorest and shifting those who can afford to pay to the private sector will reduce the burden on the government to provide family planning services.

   Limitations on access and availability of "free" products and services call for shared leadership by the public and private sectors to meet all the FP needs of Filipino men and women, with the public sector continuing to take care of the FP needs of those who are unable to pay and the private sector providing services and commodities to those who can pay. The challenge will be to direct the limited free commodities to those who need them most. National and local policies and systems need to be in place to help move those who can afford to pay out of public sector facilities. In addition, the government, both national and local, will need to adjust and strengthen the distribution system to continue to focus the delivery of "free" contraceptives to the poor.

   b. ***Client segmentation***. The targeting approach calls for redefining the coverage and segments of the Philippine family planning market. There is no guaranteed formula for market segmentation. Different approaches will be examined and tested as necessary and feasible. Some of these approaches and opportunities for segmentation, which are not mutually exclusive, include the following:

   - segmenting by ability to pay;
   - segmenting by "limiters" or "spacers" where "limiters" could be counseled about longer-term methods that might better meet their needs, e.g. IUDs and voluntary sterilization;

- geographic segmentation (urban vs. rural/hard to reach, urban/rural poor vs. urban/rural rich).

3. Creating an environment for an expanded private sector participation

A major disincentive for the private sector in increasing its supply of contraceptives is the presence of a large "free" public sector program. This is also a disincentive for clients to "demand" contraceptives from the private sector. Reducing the availability of free commodities encourages the private sector to participate and clients to frequent the private sector.

Encouraging a greater role for the private sector can allow the government to focus its efforts on reaching the poorest and hard to reach communities. A reduction of donor assistance and limited government resources will make it more difficult for the government to meet the FP needs of Filipino men and women. For this reason, the country needs to move quickly to tap the potential of the private sector as an efficient provider of services and commodities. Efforts are needed to examine and address the factors that promote or hinder private sector participation. For example, policy changes can improve the regulatory or pricing environment. Examples of these policy changes include classifying pills as over-the-counter (OTC) drug and demedicalizing FP service provision. Information derived from additional market segmentation analysis could help identify the potential market for the private sector and help encourage a private sector response that includes increasing supply of affordable contraceptives, improving quality of services, and disseminating more information about available products and services.

4. Mobilizing/Developing Financing Schemes

a. ***Cost recovery schemes***. Especially in areas where there are no private sector facilities accessible for the wealthier clients, the LGUs could institute cost recovery schemes for health services and supplies, including family planning. This would require the establishment of a system for collecting and accounting for fees, including exemption mechanisms for the poor. The fees collected could then be used to purchase resupplies. In most LGUs, this would be a matter of formalizing the current practice of receiving donations for services. A parallel effort on revenue retention should also be undertaken to ensure that LGUs retain and use the revenues generated from the collection of fees.

b. ***Including additional family planning services and commodities in the PhilHealth benefit package and helping clients avail of these services and commodities.*** PhilHealth plays an important role in sustaining the country's FP program. The current PhilHealth benefit package only includes sterilization procedures and services for IUD insertions. Expansion of the benefit package to include other modern methods such as pills, IUD devices and injectables, would further reduce the burden on government and the clients in meeting country's FP needs. Should PhilHealth achieve universal coverage, the burden would be further

reduced, especially on government resources that are being used to subsidize the cost of services and commodities for the poor or indigents.

C. Assumptions of the USAID CSR Initiative

The initiative assumes the following:

- The phase-out of USAID donations to the DOH will result in an increase in demand for private sector products.
- Private sector companies will continue to supply low-priced contraceptives.
- People in the "C" and upper "D" socio-economic group will be able and willing to pay for either private sector brands or DOH provided commodities through a cost recovery mechanism.
- LGUs will be able and willing to implement market segmentation strategies in a timely manner.
- Providers at the health centers will be able and willing to carry out means testing and then to either refer clients to the private sector or collect preset fees depending on the market segmentation model implemented by the specific LGU.
- A parallel government procurement mechanism can be initiated and funded by year 3 of the initiative to enable the first shipment of supplies to arrive at the end of year 4 or beginning of year 5.

D. Implications of the USAID CSR Initiative

This initiative represents an approach to the issue of contraceptive self reliance and faces substantial obstacles. The following obstacles are anticipated and will be addressed:

- The natural conserving tendency of a logistics system under the stress of shortages is to maintain supplies at the higher levels, resulting in rationing of supplies to the lower levels. In the Philippines, this means that free DOH supplies will tend to be more available in urban, higher-income areas, than in the rural, less developed areas where the poor are more likely to be found. Exacerbating this inequitable distribution of supplies is the fact that alternative supplies are also less likely to be found in rural areas.
- The segmentation initiative (including purchase of commodities) is at risk at three levels. First LGUs must have an entity from which they can purchase contraceptives at affordable prices. Second, the LGUs must be willing and able to implement the segmentation initiative. Last, the providers at the health centers must be willing and able to carry out means testing, referral, and/or cost recovery activities as indicated.

- Low-priced pills will be available to absorb any increase in demand. However, only three suppliers currently offer such products. One is a social marketing organization, and two are local suppliers.

- People in the C group will most likely switch to the private sector if they know about products and services available to them. Demand creation efforts consistent with the initiative will be needed.

IV. USAID technical assistance

Mindful of the challenges described above, USAID supports programs and activities that ensure the realization of the assumptions and addresses potential risks of the CSR Initiative. The USAID initiatives are described as follows:

1. Market segmentation and shifting paying clients to the private sector

This includes:

- developing a policy framework for LGUs to begin to target limited resources to the poor;
- conducting market segmentation studies;
- developing and establishing systems and guidelines for client segmentation including means testing, facilities mapping, public-private referral, collection of fees from paying clients in areas where there are no alternative sources/providers, implementing market segmentation and shifting/targeting strategies at the LGU level; and
- assessing market potential for the private sector and disseminating results to private sector stakeholders.

2. Strengthening the private sector as alternative sources of services and commodities

This includes:

- helping national government develop policies that will encourage private sector participation, such as liberalizing laws on taxation and duties for contraceptive products, reclassifying contraceptive pills as over-the-counter drugs which can be more freely advertised;
- assessing and leveraging private sector potential which involves documenting clients' ability and willingness to pay as well as the availability of products and services;
- encouraging the development of sustainable and affordable supply of commodities in the private sector, including working with existing contraceptive manufacturers and marketers that cater to C and D groups;

- encouraging increased delivery of FP services through private sector providers and using mass media campaigns that direct consumers to private sector products, outlets and service centers; and
- provider training and intensified detailing activities to expand the number of private physicians capable of offering family planning services.

3. Building the capacity of LGUs in planning, budgeting, and logistics

This includes:

- helping government develop policies that will create an enabling environment for improved FP services and commodities delivery at the LGUs;
- careful system modification and strengthening LGUs in their capacity to manage commodities so that the donated supplies remaining in the system over the next few years reach the appropriate clients;
- building/strengthening LGU capacity to procure contraceptives at reasonable prices; and
- developing LGU capacities in forecasting supply, planning and procurement.

4. Expanding and accessing financing schemes, such as PhilHealth

This includes:

- expanding the PhilHealth benefit package to include broader coverage of family planning;
- intensifying information on current PhilHealth benefits;
- establishing PhilHealth systems for reimbursement and streamlining procedures for accreditation of providers;
- promoting enrollment of indigents with PhilHealth; and
- working with business leaders and health insurance companies to expand coverage to include FP benefits.

5. Facilitating the growth of demand for family planning

This includes:

- operationalization of communication and advocacy strategies to achieve greater social acceptance of family planning among the public, including:
  - increasing health literacy and improving flow of accurate information about family planning
  - increasing dialogue about family planning and credibility of health providers and medical professionals as sources of information
  - raising cultural legitimacy of family planning
  - building local capacities for family planning, and
  - integrating family planning into routine health services, such as workplace referrals to private service centers

- dissemination and educational activities targeted at private medical providers and pharmacists to expand coverage of family planning, including:
  - expanding in-service medical training and continuing education programs for providers,
  - forming partnerships with provider associations to support educational opportunities for members, and
  - developing educational materials for dissemination to providers and pharmacists.

6. Supporting sustained advocacy efforts targeted to policymakers, the private sector and other key stakeholders

This includes:

- sustained advocacy efforts for the establishment of a country policy on FP service and commodity provision and financing;
- establishment and strengthening groups to create and expand FP market demand; and
- collaboration with major business associations to:
  - promote public debate/discussions on the need for effective population management,
  - increase the business sector's awareness of the challenges and opportunities of effective population management initiatives and mobilize these associations for advocacy and action on service delivery/expanded coverage of health insurance for employees, and
  - capitalize on the status and influence of these associations in national policy making and implementation.

V. Monitoring and Coordination

Benchmarks for the CSR initiative will be developed. In addition to the changes in the sources of commodities, other benchmarks that affect transition plans will be defined and laid out in a parallel timeline.

On an ongoing basis, a strong feedback mechanism will be built so that progress and implications of country response can be understood and responded to efficiently and effectively.

This includes:

- tracking of consumption after reducing allocation and monitoring client responses to reduced supply to ensure that those who have been targeted to be shifted to the private sector go to private sector service centers;
- monitoring commercial supply of all commodities to ensure availability of commodities and continued use of method of choice;
- developing strategies to ensure continued increase in CPR;
- developing benchmark indicators for the CSR initiative; and
- conducting regular evaluation and review, e.g mid-term evaluation, initiative review, validation of assumptions, and others as needed.

A coordination mechanism between and among stakeholders will be developed. The coordination mechanism will define the potential roles of the various stakeholders, the process for consultation and interaction, and identify synergies of activities. The CSR stakeholders outside USAID include the relevant GRP agencies, LGUs, other donors, business groups, and private sector providers and service centers.

List of Annexes